Compass Oncology

ASSIGNMENT OF BENEFITS/FINANCIAL RESPONSIBILITIES

Today's Date: _____

Patient Name: _____ ( ) _____
Last First M.I. Home Telephone

Cell ( ) _____

Home Address: _____ Mailing Address: _____
Street *Street*

_____ _____
City State Zip *City State Zip*

DOB: _____ Age _____ ☐M ☐F SS# _____ ☐Married ☐Single ☐Divorced ☐Widowed ☐Other
Sex *Check Marital Status*

Email: _____ Race: _____

Ethnicity* Hispanic/Latino ____Yes ____ No

Preferred Language*: _____

Preferred Contact Method: (circle one) Cell Home Work Email Home address

Cell number: _____

Employer _____ ( ) _____
Name *Telephone*

_____ _____
Address Occupation

Responsible Party: _____ _____ ( ) _____
Name Relationship Telephone

Emergency Contact:
Spouse/Next of Kin: _____ _____ ( ) _____
Name Relationship *Telephone*

Referring Physician: _____ Primary Care Physician: _____

Primary Ins: _____ Telephone:( )

Insured Name: _____ DOB _____ Group #_____ Policy #_____

Secondary Ins: _____ Telephone:( ) _____

Insured Name: _____ DOB _____ Group #:_____ Policy # _____

1. I understand that I am responsible for charges not covered or reimbursed by the above agents. I agree, in the event of non-payment, to assume the costs of interest, collection and legal action (if required).
2. I authorize my insurance carrier to release information regarding my coverage to Compass Oncology.
3. My right to payment for all pharmaceuticals, procedures, tests, medical equipment rentals, supplies and nursing/physician services including major medical benefits are hereby assigned to Compass Oncology. This assignment covers any and all benefits under Medicare, other government sponsored programs, private insurance and any other health plans. I acknowledge this document as a legally binding assignment to collect my benefits as payment of claims for services. In the event my insurance carrier does not accept Assignment of Benefits, or if payments are made directly to me or my representative, I will endorse such payments to Compass Oncology.
4. I understand that I have a right to request and receive a Notice of Privacy Practices from Compass Oncology.

THIS AGREEMENT/CONSENT WILL REMAIN IN EFFECT UNLESS REVOKED BY ME IN WRITING.

I have read and received a copy of the above statements and accept the terms. A duplicate of the statement is considered the same as original.

_____ _____
Patient Signature Date/Time AM or PM (*circle one*)

_____ _____
Responsible Party Signature Relationship Date/Time AM or PM (*circle one*)

PHYSICIAN: _____
ACCT NBR: _____ LOC: _____
FOR OFFICE USE ONLY

EMPLOYEE INITIALS _____

Revised Feb 2012